MEDICARE LEARNING NETWORK - COMPUTER/WEB-BASED TRAINING

HCFA FORM 1450 - Version UB-92
FILING YOUR CLAIM TO MEDICARE PART A

Let's start by determining how much you already know about filing the HCFA-1450.

What follows is a short quiz. When you've answered all the questions, you'll be given feedback and you'll learn your score. This will give you a pretty good idea of your current level of knowledge and comfort with the subject.

OK, let's go!

IMPORTANT

Make sure you select an answer on each screen before clicking the Right Arrow to continue. You are not allowed to go back to screens in the Preliminary Knowledge Assessment, and any unanswered questions will be counted as incorrect.

Pretest

Type of bill code 75X represents a bill from a Community Mental Health Center (CMHC) provider.

- True
- False

Condition Code 11 must be reported on all bills (inpatient and outpatient) if therapy services were performed.

- True
- False

The patient's birthday must be reported using a four-digit year (MMDDYYYY).

- True
- False

The Patient Control Number should be entered in Form Locator 3.

- True
- False

Select the appropriate association between the six items.

1. First Digit	2. Second Digit	3. Third Digit
A. Frequency	B. Facility	C. Bill Classification

1.B 2.A 3.C

1.B 2.C 3.A

1.C 2.B 3.A

1.C 2.A 3.B

(1) What is the type of bill code for an inpatient (Part A) hospital adjustment bill?

(2) What is the type of bill code for an inpatient (Part B only) ancillary cancel/void bill?

(1) 177 (2) 182
(1) 17 (2) 28
(1) 128 (2) 117
(1) 117 (2) 128

Form locator 20, Source of Admission, is a required entry for what kinds of bills?

- Inpatient only
- Outpatient only
- Inpatient and Outpatient
- None of the above

Form locator 23 is an optional entry field. If it is used, the Medical Record Number should be entered.

- True
- False

Which occurrence code number should be used to report an Onset of Symptoms/Illness?

Form locators 39-41: What is the title of this field?

Revenue code 001 (total charges) should always be the final entry on the claim.

- True
- False

Form Locator 44 is used to report applicable rates for inpatient claims and HCPCS codes for outpatient claims.

- True
- False

Hospital outpatient claims containing CPT/HCPCS clinical diagnostic laboratory codes and spanning two or more days of service must have line item service dates reported.

- True
- False

"Payer Identification" (form locator 50) does not have to be reported in any particular order (e.g., primary, secondary, etc.)

- True
- False

A provider number is a required entry on the UB92.

- True
- False

Good try! You scored ___ correct on the Preliminary Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click a numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

It is advised that you proceed through all the Form Locator lessons beginning with number one to increase your understanding of the 1450 Form.

Take the Post-Course Knowledge Assessment after you have completely reviewed all of the course lessons.

Overview

The HCFA 1450 (UB-92) form and instructions are used by institutional and other selected providers to complete a Medicare Part A paper claim for submission to Medicare Intermediaries. The paper Form HCFA-1450 is neither a government printed form nor distributed by the Health Care Financing Administration. The National Uniform Billing Committee is responsible for the design of the form. You may obtain copies of the paper Form HCFA (also known as the UB-92 form) from the Standard Register Company, Forms Division. Their phone number may be found in your local yellow pages.

NOTE: The values and entries entered on a HCFA-1450 paper claim form can also be submitted electronically. Medicare encourages the submission of claims electronically. Medicare encourages the submission of claims electronically, instead of submitting paper claims, whenever feasible.

To keep abreast of all of the latest changes in HCFA billing and coding requirements, go to the following HCFA web site:

www.hcfa.gov

HCFA 1450 Form (Full View)

This is the HCFA-1450 form, which you'll be learning about in this module. Click the Right Arrow to see a scrollable zoomed-in view of the form, which you can click on to see more information about specific parts of the form.

Click the Right Arrow and let's begin!

To print the form, click the button below.

Print

Scroll the HCFA 1450 form using the buttons along its sides. Click on an area on the form for more information. When finished, click on the Post-Course Knowledge Assessment to check your knowledge and complete the course.

Move your mouse over the form to see information here.

Click here for Post-Course Knowledge Assessment

Form Locator 1

Title: Provider Name, Address and Telephone Number

Definition: The name of the provider submitting the bill and the complete mailing address.

Requirements: Entry is required. Minimum is provider name, city, state and zip.

Field Attributes: 25 positions, alphanumeric, left justified

Notes: Enter the information required on the appropriate line:

Line 1 = Provider Name
Line 2 = Street Address or Post Office Box
Line 3 = City, State and Zip Code
Line 4 = Telephone

If a nine digit zip code is used, use the following format XXXXX-XXXX (32202-1234)

Form Locator 3

Title: Patient Control Number

Definition: Patient's unique alphanumeric number assigned by the provider to facilitate retrieval of individual financial records and posting of reimbursement.

Requirements: Entry is optional.

Field Attributes: 20 positions, alphanumeric, left justified.

Notes: Enter the patient control number assigned by you, the provider. This number will be communicated back to providers on the financial remittance advice (and other various intermediary reports) to allow more effective Medicare account identification.

What should be entered in Form Locator 3?

Is the information in Form Locator 3 required?

- Yes
- No

Form Locator 4

FL 4. Type of Bill Required.

This three-digit alphanumeric code gives three specific pieces of information. The first digit identifies the type of facility. The second classifies the type of care. The third indicates the sequence of this bill in this particular episode of care. It is a "frequency" code.

Code Structure (Only codes used to bill Medicare are shown.)

1st Digit - Type of Facility
1 - Hospital
2 - Skilled Nursing
3 - Home Health
4 - Religious Non-Medical (Hospital)
5 - Religious Non-Medical (Extended Care)
6 - Intermediate Care
7 - Clinic or Hospital Based Renal Dialysis Facility (requires special information in second digit below).
8 - Special facility or hospital ASC surgery (requires special information in second digit below).
9 - Reserved for National Assignment

2nd Digit-Bill Classification (Except Clinics and Special Facilities)
1 - Inpatient (Part A)
2 - Hospital Based or Inpatient (Part B) (includes HHA visits under a Part B plan of treatment).
3 - Outpatient (includes HHA visits under a Part A plan of treatment and use of HHA DME under a Part A plan of treatment).
4 - Other - Part B - (includes HHA medical and other health services not under a plan of treatment, SNF diagnostic clinical laboratory services to "nonpatients," and referenced diagnostic services).
5 - Intermediate Care - Level I
6 - Intermediate Care - Level II
7 - Subacute Inpatient (Revenue Code 19X required)
8 - Swing Bed (may be used to indicate billing for SNF level of care in a hospital with an approved swing bed agreement).
9 - Reserved for National Assignment

2nd Digit-Classification (Clinics Only)

1 - Rural Health Clinics (RHC)
2 - Hospital Based or Independent Renal Dialysis Facility
3 - Free Standing Provider-Based Federally Qualified Health Centers (FQHC)
4 - Other Rehabilitation Facility (ORF)
5 - Comprehensive Outpatient Rehabilitation Facility (CORF)
6 - Community Mental Health Center
7-8 - Reserved for National Assignment
9 - OTHER

2nd Digit-Classification (Special Facilities Only)
1 - Hospice (Non-Hospital Based)
2 - Hospice (Hospital Based)
3 - Ambulatory Surgical Center Services to Hospital Outpatients
4 - Free Standing Birthing Center
5 - Critical Access Hospital
6-8 Reserved for National Assignment
9 - OTHER

3rd Digit-Frequency	Definition:
A - Hospice Admission Notice	Use when the hospice is submitting Form HCFA-1450 as an Admission Notice.
B - Hospice Termination/Revocation Notice	Use when the hospice is submitting Form HCFA-1450 as a notice of termination/revocation for a previously posted hospice election.
C - Hospice Change of Provider Notice	Use when Form HCFA-1450 is used a Notice of change to the hospice provider.
D - Hospice Election Void/Cancel	Use when Form HCFA-1450 is used as a Notice of a Void/Cancel of hospice election.
E - Hospice Change of Ownership	Use when Form HCFA-1450 is used as a Notice of Change in Ownership for the hospice.
F - Beneficiary Initiated Adjustment Claim	Used to identify adjustments initiated by the beneficiary. For intermediary use only.
G - CWF Initiated Adjustment Claim	Used to identify adjustments initiated by CWF. For intermediary use only.
H - HCFA Initiated Adjustment Claim	Used to identify adjustments initiated by HCFA. For intermediary use only.
I - Intermediary Adjustment Claim (Other than Pro or Provider)	Used to identify adjustments initiated by the intermediary. For intermediary use only.
J - Initiated Adjustment Claim - Other	Used to identify adjustments initiated by other entities. For intermediary use only.
K - OIG Initiated Adjustment Claim	Used to identify adjustments initiated by OIG. For intermediary use only.
M - MSP Initiated Adjustment claim	Used to identify adjustments initiated by MSP. For intermediary use only. Note: MSP takes precedence over other adjustment sources.
P - PRO Adjustment claim	Used to identify an adjustment initiated as a result of a PRO review. For intermediary use only.
O - Nonpayment/Zero Claims	Use this code when you do not anticipate payment from the payer for the bill,, but is informing the payer about a period of nonpayable confinement or termination of care. The "Through" date of this bill (FL6) is

	the discharge date for this confinement. Medicare requires "nonpayment" bills only to extend the spell-of-illness in inpatient cases. Other nonpayment bills are not needed and may be returned to you.
1- Admit Through Discharge Claim	Use this code for bill encompassing an entire inpatient confinement or course of outpatient treatment for which you expect payment from the payer or which will update deductible for inpatient or Part B claims when Medicare is secondary to an EGHP.
2 - Interim - First claim	Use this code for the first of an expected series of bills for which utilization is chargeable or which will update inpatient deductible for the same confinement of course of treatment.
3 - Interim-Continuing Claims (Not valid for PPS bills)	Use this code when a bill for which utilization is chargeable for the same confinement or course of treatment had already been submitted and further bills are expected to be submitted later.
4 - Interim - Last Claim (Not valid for PPS Bills)	Use this code for a bill for which utilization is chargeable, and which is the last of a series for this confinement or course of treatment. The "Through" date of this bill (FL6) is the discharge for this treatment.
5 - Late Charge Only	Use for outpatient claims only. Late charges are not accepted for Medicare inpatient or ASC claims.
7 - Replacement of Prior Claim	Use to correct a previously submitted bill. Apply this code to the corrected or "new" bill.
8 - Void/Cancel of a Prior Claim	Use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A code "7" (Replacement of Prior Claim) is being submitted showing corrected information.

Select the appropriate association between the six items.

1. First Digit	2. Second Digit	3. Third Digit
A. Frequency	B. Facility	C. Bill Classification

1. B 2. A 3. C
1. B 2. C 3. A
1. C 2. B 3. A
1. C 2. B 3. A

(1) What is the type of bill code for an inpatient (Part A) hospital adjustment bill?

(2) what is the type of bill code for an inpatient (Part B only) ancillary cancel/void bill?

(1) 177 (2) 182
(1) 17 (2) 28
(1) 128 (2) 117
(1) 117 (2) 128

Form Locator 6

Title: Statement Covers Period

Definition: The beginning and ending service dates of the period included by this bill.

Requirements: Entry is required.

Field Attributes: 12 positions, numeric, right justified

Notes:

- Enter the dates in month, date and year format (MMDDYYYY). Example: 100011996
- Inpatient claims for providers who are not reimbursed under the prospective payment system (non-PPS) may not span the provider's fiscal year end.
- Outpatient claims may not span calendar years
- Do not report service dates prior to the patient's entitlement to Medicare

Form Locator 7

Title: Covered Days

Definition: Enter the number of Medicare covered days.

Requirements: Entry is required, if applicable (inpatient only)

Field Attributes: 3 positions, numeric, right justified.

Notes:

- Enter the total number of covered days during the billing period from Form Locator 6 which are applicable to the cost report, including the lifetime reserve days elected.

- The numeric entry reported in this form locator should be the same total as the total number of covered accommodation units reported in Form Locator 46.

- Exclude any days classified as non-covered and leave of absence days. Refer to Form Locator 8.

- Exclude the day of discharge or death unless the patient is admitted and discharged the same day.

- Do not deduct days for payment made by another primary payer such as:

    - Worker's Compensation or Black Lung
    - Veteran's Administration
    - Automobile Medical, No-Fault or Liability insurance
    - Employer Group Health Plan for employed beneficiaries/spouses age 65 and over
    - Employer Group Health Plan for an End Staged Renal Disease beneficiary
    - Large Group Health Plan for disabled beneficiaries.

Form Locator 8

Title: Non-Covered Days

Definition: Enter the number of days not covered by Medicare.

Requirements: Entry is required, if applicable.

Field Attributes: 4 positions, numeric, right justified.

Notes:

- Enter the total number of non-covered days during the billing period from Form Locator 6 that are not claimable as Medicare payment days on the cost report and for which the beneficiary will not be charged utilization for Medicare Part A services.

- The reason for non-coverage should be explained by occurrence codes in Form Locators 32-35, and/or occurrence span codes in Form Locator 36. Provide a brief explanation of any non-covered days not describes by occurrence codes in Form Locator 84, "Remarks."

- Day of discharge or death is not counted as a non-covered day.

- Do not report non-covered days for payment made by another primary payer such as:

    - Worker's Compensation or Black Lung
    - Veterans Administration
    - Automobile Medical, No-Fault or Liability insurance
    - Employer Group Health Plan for employed beneficiaries/spouses age 65 and over
    - Employer Group Health Plan for an End Staged Renal Disease beneficiary
    - Large Group Health Plan for disabled beneficiaries

Form Locator 9

Title: Coinsurance Days

Definition: The inpatient Medicare hospital days occurring after the 60th day and before the 91st day in a single spell of illness or benefit period; and the inpatient skilled nursing facility (SNF) days occurring after the 20th day through the 101st day in a single spell of illness.

Requirements: Entry is required, if applicable.

Field Attributes: 3 positions, numeric, right justified.

Benefit Period Table: Click on each number below to see benefits

- Inpatient hospital stay 1st through 60th day (FULL DAYS)
- Inpatient hospital stay 61st through 90th day (COINSURANCE DAYS)
- Inpatient hospital 91st through 150th day (LIFETIME RESERVE DAYS)
- Skilled Nursing Facility stay 1st day through 20th day (SNF COINSURANCE DAYS)
- Skilled Nursing Facility stay 21st day through 100th day (SNF COINSURANCE DAYS)

Form Locator 10

Title: Lifetime Reserve Days (LTR)

Definition: Under Medicare, each beneficiary has a lifetime reserve (LTR) of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services in a benefit period.

Requirements: Entry is required, if applicable.

Field Attributes: 3 positions, numeric, right justified

Notes:

- It should be noted that the beneficiary's 60 days are a lifetime benefit and are not renewable.

- If the adjudication of a claim warrants the use of lifetime reserve days, the intermediary will automatically apply the appropriate days, unless the beneficiary specially elected not to utilize their LTR days.

Form Locator 11

Title: UNTITLED

Form Locator 12

Title: PATIENT NAME

Definition: last name, first name and middle initial of the patient.

Requirements: Entry required. Enter the following patient information: Last name, first name, middle initial, if any.

Field Attributes: 30 positions, alphanumeric, left justified

Note: Name must be the same as on the patient's Health Insurance Card or other Medicare notice.

The following guidelines should be followed unless the Medicare card dictates otherwise.

- No space should be left between a prefix and a name as in MacBeth, VonSchmidt, McEnroe.
- Titles (such as Sir, Msgr., Dr.) should not be recorded in this data element.
- Record hyphenated names with hyphen as in Smith-Jones, Rebecca.
- To record suffix of a name, write the last name, leave a space and write the suffix, then write the first name as in Snyder III, Harold, or Addams Jr., Glen.

Form Locator 13

Title: PATIENT ADDRESS

Definition: The address of the patient.

Requirements: Entry required. Enter the following information: full mailing address, including street number and name or post office box number or RFD; city name; state name; zip code.

Field Attributes: 50 positions, alphanumeric, left justified

Note: Use the Standard Post Office State Abbreviations and Zip Code Instructions as defined in Form Locator 1.

Click for a complete list of Post Office State Abbreviations!

Abbreviations

ALABAMA	AL
ALASKA	AK
ARIZONA	AZ
ARKANSAS	AR
CALIFORNIA	CA
COLORADO	CO
CONNECTICUT	CT
DELAWARE	DE
DISTRICT OF COLUMBIA	DC
FLORIDA	FL
GEORGIA	GA
HAWAII	HI
IDAHO	ID
ILLINOIS	IL
INDIANA	IN
IOWA	IA
KANSAS	KS
KENTUCKY	KY
LOUISIANA	LA
MAINE	ME
MARYLAND	MD
MASSACHUSETTS	MA
MICHIGAN	MI
MINNESOTA	MN
MISSISSIPPI	MS
MISSOURI	MO
MONTANA	MT
NEBRASKA	NE
NEVADA	NV
NEW HAMPSHIRE	NH
NEW JERSEY	NJ
NEW MEXICO	NM
NEW YORK	NY
NORTH CAROLINA	NC
NORTH DAKOTA	ND
OHIO	OH
OKLAHOMA	OK
OREGON	OR
PENNSYLVANIA	PA
RHODE ISLAND	RI
SOUTH CAROLINA	SC
SOUTH DAKOTA	SD
TENNESSEE	TN

TEXAS	TX
UTAH	UT
VERMONT	VT
VIRGINIA	VA
WASHINGTON	WA
WEST VIRGINIA	WV
WISCONSIN	WI
WYOMING	WY
AMERICAN TERRITORIES	
AMERICAN SAMOA	AS
CANAL ZONE	CZ
PUERTO RICO	PR
TRUST TERRITORIES	TT
VIRGIN ISLANDS	VI
CANADIAN PROVINCES	
ALBERTA	AB
BRITISH COLUMBIA	BC
LABRADOR	IB
MANITOBA	MB
NEW BRUNSWICK	NB
NEWFOUNDLAND	NF
NORTHWEST TERRITORIES	NT
NOVA SCOTIA	NS
ONTARIO	ON
PRINCE EDWARD ISLE	PE
QUEBEC	QB
SASKATCHEWAN	SK
YUKON	YK

Form Locator 14

Title: PATIENT BIRTHDATE

Definition: The date of birth of the patient.

Requirements: Entry required. Enter the month, day and year of birth.

Field Attributes: 8 positions, numeric, right justified (all positions fully coded)

Note: The birth year has been expanded to four digits to report the complete year of birth.

Enter the date in two-digit month, two-digit day, and four-digit year format (MMDDYYYY).

Example: June 27, 1902, should be reported as 06271902

Form Locator 15

Title: PATIENT SEX

Definition: The sex of the patient as recorded at date of admission, outpatient service, or start of care.

Requirements: Entry required.

Field Attributes: 1 position, alphanumeric, left justified

Code Structure: M = Male
F = Female

Note: This entry is used in conjunction with diagnoses and procedure code entries (Form Locators 67-81) to identify inconsistencies.

Form Locator 16

Title: Patient Marital Status

Definition: The marital status of the patient at date of admission, outpatient service or start of care.

Requirements: Entry is optional.

Field Attributes: 1 position, alphanumeric, left justified

Code Structure:

S = Single
M = Married
L = Legally Separated
D = Divorced
W = Widowed
U = Unknown

Form Locator 17

Title: Admission Date

Definition: The date the patient was admitted to the provider for inpatient care.

Requirements: Entry is required for inpatient services.

Field Attributes: 8 positions, numeric, right justified

Notes: Enter the admission date in month, day and year format (MMDDYYYY).
Example: 10011996

Form Locator 19

Title: Type of Admission

Definition: A code indicating the priority of this admission.

Requirements: Entry is required for inpatient services.

Field Attributes: 1 position, alphanumeric, left justified

Code Structure:

1 = Emergency
2 = Urgent
3 = Elective
4 = Newborn
5-8 = Reserved (do not use)
9 = Information not available

Form Locator 20

Title: Source of Admission

Definition: A code indicating the source of this admission.

Requirements: Entry is required for hospital inpatient admissions and outpatient registrations.

Field Attributes: 1 position, alphanumeric, left justified

Code Structure: Click here for Source of Admission definitions!
(For Emergency, Elective or Other Types of Admission)

1 = Physician Referral
Inpatient: The patient was admitted to this facility upon the recommendation of his or her personal physician.
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by his or her personal physician or the patient independently requested outpatient services (self-referral).

2 = Clinical Referral
Inpatient: The patient was admitted to this facility upon recommendation of this facility's clinic physician.
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by this facility's clinic or other outpatient department physician.

3 = HMO Referral
Inpatient: The patient was admitted to this facility upon the recommendation of a Health Maintenance Organization (HMO) physician.
Outpatient: The patient was referred to this facility for outpatient or referenced diagnostic services by a Health Maintenance Organization (HMO) physician.

4 = Transfer from an Acute Care Facility
Inpatient: The patient was admitted to this facility as a hospital transfer from an acute-care facility where he or she was an inpatient.
Outpatient: The patient was referred

4 = Transfer from Hospital
5 = Transfer from a Skilled Nursing Facility
6 = Transfer from another Health Care Facility
7 = Emergency Room
8 = Court/Law Enforcement
9 = Information
A = Transfer from a Rural Primary Care Hospital
B-Z = Reserved (do not use)

Form Locator 22

Title: PATIENT STATUS

Definition: A code indicating patient status as of the "Through" date reported in the Statement Covers Period (Form Locator 6).

Requirements: Entry required for inpatient and outpatient bills.

Field Attributes: 2 positions, numeric, right justified (all positions fully coded)

Code Structure:

01	Discharged to home or self-care (routine discharge).
02	Discharged/transferred to another short-term general hospital for inpatient care. NOTE: For hospitals reimbursed under the prospective payment system (PPS), this patient status will result in a per diem payment to the transferring hospital and the full (DRG) payment will be made to the receiving hospital.
03	Discharged/transferred to skilled nursing facility (SNF).
04	Discharged/transferred to an intermediate care facility (ICF).
05	Discharged/transferred to another type of institution for inpatient care or referred for outpatient services to another institution.
06	Discharged/transferred to home under care of organized home health service organization.
07	Left against medical advice or discontinued service.
08	Discharged/transferred to home under care of a Home IV provider.
09*	Admitted as an inpatient to this hospital.
10-19	Discharge to be defined at state level, if necessary.
20	Expired.
21-29	Expired to be defined at state level, if necessary.
30	Still patient or expected to return for outpatient services.
31-39	Still patient to be defined at state level, if necessary.
40**	Expired at home.
41**	Expired in a medical facility; e.g., hospital, SNF, ICF, or free-standing hospice.
42**	Expired - place unknown.
43-49	Reserved for national assignment.
50	Hospice - home.
51	Hospice - medical facility
52-59	Reserved for national assignment.
*	For use only on Medicare outpatient claims.

In situations where a patient is admitted to an inpatient hospital that is reimbursed under the prospective payment system (PPS) before midnight of the day following the day of an outpatient service, the outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began more than 3 days earlier, such an observation following outpatient surgery, which results in admission.

In situations where a patient is admitted to an inpatient hospital or a unit within the hospital that is exempt from reimbursement under the prospective payment system (nonplus) before midnight under the prospective payment system (nonplus) before midnight of the day following the day of an outpatient service, the outpatient services are considered inpatient. Therefore, code 09 would apply only to services that began more than 1 day earlier.

** For use only on Medicare claims for hospice care.

Form Locator 23

Title: Medical Record Number

Definition: The number assigned to the patient's medical/health record by the provider.

Requirements: Entry is optional.

Field Attributes: 17 positions, alphanumeric, left justified.

Notes: The medical record number is typically used to do an audit of the history of treatment. It should not be substituted for the Patient Control Number in form locator 3. However, the Patient Control Number may be the same number reported as the Medical Record Number and vice versa.

Form Locator 23 is an optional entry field. If it is used, what should be entered?

Form Locator 24-30

Title: CONDITION CODES

Definition: A code(s) used to identify conditions relating to this bill that may affect claim processing.

Requirements: Entry required, if applicable.

Field Attributes: 2 positions, alphanumeric, all positions fully coded

Code	Title	Definition
02	Condition is Employment	Enter this code if the patient related alleges that the medical condition causing this episode of care is due to environment/events resulting from his employment.
04	Patient is HMO Enrollee	Enter this code to indicate the patient is a member of an HMO .
05	Lien Has Been Filed	Enter this if you have filed legal claim for recovery of funds potentially due to a patient as a result of legal action initiated by or on behalf of a patient.
06	ESRD Patient in the First 30 Months of Entitlement Covered by Employer Group Health Insurance	Enter this code if Medicare may be a secondary insurer if the patient is also covered by employer group health insurance during his first 30 months of end stage renal disease entitlement.
07	Treatment of Nonterminal Condition for Hospice Patient	Enter this code to indicate the patient has elected hospice care, but you are not treating the patient for the terminal condition and are, therefore, requesting regular Medicare payment.
08	Beneficiary Would Not Provide Information Concerning Other Insurance Coverage	Enter this code if the beneficiary would not provide you with information concerning other insurance coverage.
09	Neither Patient Nor Spouse is Employed	Enter this code to indicate that in response to development questions, the patient and spouse have denied employment.
10	Patient and/or Spouse is Employed but no EGHP Coverage Exists	Enter this code to indicate that in response to development questions, the patient and/or spouse indicated that one or both are employed but have no group health insurance under an EGHP or other employer

		sponsored or provided health insurance that covers the patient.
11	Disabled Beneficiary But no LGHP	Enter this code to indicate that in response to development questions, the disabled beneficiary and/or family member indicated that one or more are employed, but have no group coverage from an LGHP or provided health insurance will not report them.
12-16	Payer Codes	Codes reserved for internal use only by third party payers.
20	Beneficiary Requested Billing	Enter this code to indicate the services on this bill are at a noncovered level of care or otherwise excluded from coverage, but the beneficiary has requested a formal determination.
21	Billing for Denial Notice	Enter this code to indicate you realize services are at a noncovered level of care or excluded, but you are requesting a denial notice from Medicare in order to bill Medicaid or other insurers.
26	VA Eligible Patient Chooses to Receive Services in Medicare Certified Facility	Enter this code if a patient is VA eligible and chooses to receive services in a Medicare certified facility instead of a VA facility.
27	Patient Referred to a Sole Community Hospital for a Diagnostic Laboratory Test	(Sole Community Hospitals only). Enter this code to indicate the patient was referred for diagnostic laboratory test. Use to indicate laboratory service is paid at 62 percent fee schedule rather than 60 percent fee schedule.
28	Patient and/or Spouse's EGHP is Secondary to Medicare	Enter this code to indicate that, in response to development questions the patient and/or spouse have indicated that one or both are employed and that

		there is group health insurance from an EGHP or other employer-sponsored or provided health insurance that covers the patient but that either: (1) the EGHP is a single employer plan and the employer has fewer than 20 full- and part-time employees; or (2) the EGHP is a multi or multiple employer plan that elects to pay secondary to Medicare for employees and spouses aged 65 and older for those participating employers who have fewer than 20 employees.
29	Disabled Beneficiary and/or Family Member's LGHP is Secondary to Medicare	Enter this code to indicated that in response to development questions, the patient and/or family member(s) are employed and there is group health insurance coverage under an LGHP or other employer sponsored or provided health insurance that covers the patient but that either: (1) the LGHP is a single employer plan and that the employer has fewer than 100 full- and part-time employees; or, (2) the LGHP is a multi or multiple employer plan and that all employers participating in the plan have fewer than 100 full- and part-time employees.
30	Reserved for National Assignment.	
31	Patient is a Student (Full Time - Day)	Patient declares that he/she is enrolled as a full-time day student.
32	Patient is a Student (Cooperative/Work Study Program)	Patient declares that he/she is enrolled in a cooperative work study program.
33	Patient is a Student (Full Time - Night)	Patient declares that he/she is enrolled as a full-time night student.

34	Patient is a Student (Part-Time)	Patient declares that he/she is enrolled as a part-time student.
ACCOMMODATIONS		
Code	Title	Definition
35	Reserved for National Assignment	
36	General Care Patient in a Special Unit	(Not used by hospitals under PPS.) Enter this code to indicate you temporarily placed the patient in a special care unit because no general care beds were available. Accommodate charges for this period are at the prevalent semi-private rate.
37	Ward Accommodation at Patient's Request	Enter this code if the patient was assigned to ward accommodations at his/her own request.
38	Semi-private Room Not Available	Enter this code to indicate that either private or ward accommodations were assigned because semi-private accommodations were not available.
39	Private Room Medically Necessary	(Not used by hospitals under PPS.) Enter this code if the patient needed a private room for medical necessity.
40	Same Day Transfer	Enter this code if the patient was transferred to another participating Medicare provider before midnight on the day of admission.
41	Partial Hospitalization	Enter this code when claim is for partial hospitalization services. For outpatient services, this includes a variety of psychiatric programs (such as drug and alcohol).
55	SNF Bed Not Available	Enter this code to indicate the patient's SNF admission was

		delayed more than 30 days after hospital discharge because a SNF bed was not available.
56	Medical Appropriateness	Enter this code to indicate the patient's SNF admission was delayed more than 30 days after hospital discharge because the patient's condition made it inappropriate to begin active care within that period.
57	SNF Readmission	Enter this code to indicate the patient previously received Medicare-covered SNF care within 30 days of the current SNF admission.
60-65	Payer Codes	(For use by third party payers only.)
66	Hospital Does Not Wish Cost Outlier Payment	Enter this code to indicate you are not requesting additional payment for this stay as a cost outlier. (Used only by hospitals paid under PPS.)
67	Beneficiary Elects Not Use Lifetime Reserve (LTR) Days	Enter this code to indicate that the beneficiary elects not to use LTR days.
68	Beneficiary Elects to Use LTR Days	Enter this code to indicate that the beneficiary elects to use LTR days when charges are less than LTR coinsurance amounts.
70	Self-Administered Epoetin (EPO)	Enter this code to indicate the billing is for a home dialysis patient who self-administers EPO.
71	Full Care in Unit	Enter this code to indicate the billing is for a patient who received staff-assisted dialysis services in a hospital or renal dialysis facility.
72	Self-Care in Unit	Enter this code to indicate the billing is for a patient who managed his/her own dialysis services without staff assistance in a hospital or renal dialysis facility.

73	Self-Care Training	Enter this code to indicate billing is for special dialysis services where a patient and his/her helper (if necessary) were learning to perform dialysis.
74	Hospital	Enter this code to indicate the billing is for a patient who received dialysis services at home.
75	Home 100-percent Payment	(Not to be used for services furnished 4/16/90, or later.) Enter this code to indicate the billing is for a patient who received dialysis services at home using a dialysis machine that was purchased under the 100-percent program.
76	Back-up In-Facility Dialysis	Enter this code to indicate the billing is for a home dialysis patient who received back-up dialysis in a facility.
77	Provider Accepts or is Obligated/Required Due to a Contractual Arrangement or Law to Accept Payment by a Primary Payer as Payment in Full	Enter this code to indicate you have accepted or are obligated/required to accept payment as payment in full due to a contractual arrangement or law. Therefore, no Medicare payment is due.
78	New Coverage Not Implemented by HMO	Enter this code to indicate billing is for a newly covered service under Medicare for which an HMO does not pay. (For outpatient bills, condition code 04 should be omitted.)
79	CORF Services Provided Off-Site	Enter this code to indicate that physical therapy, occupational therapy or speech pathology services were provided off-site.

Special Program Indicator Codes Required. The only special program indicators that apply to Medicare are:

A3	Special Federal Funding	This code has been designed for uniform use by State uniform billing committees.
A5	Disability	This code has been designed for uniform use by State uniform billing committees.
A6	Medicare Pneumococcal Pneumonia Vaccine (PPV); Influenza Virus Vaccine	This code identifies the services given that are to be paid under special Medicare program provisions.
A7	Induced Abortion --Danger to Life	Abortion was performed to avoid danger to woman's life.
A8	Induced Abortion--Victim Rape/Incest	Self-explanatory.
A9	Second Opinion Surgery	Services requested to support second opinion in surgery. Part B deductible and coinsurance do not apply.
MO-M9	Payer Only Codes	
MO	All-Inclusive Rate for Outpatient	Used by a Rural Primary Care Hospital electing to be paid on an all-inclusive rate for outpatient services.
M1	Roster Billed Influenza Virus Vaccine or PPV	Enter this code to indicate the influenza virus vaccine or PPV is being billed via the roster billing method by providers that mass immunize.
M2	HHA Payment Significantly Exceeds Total Charges	Used when payments to an HHA is significantly in excess of covered billed charges.

PRO Approval Indicator Codes		
Code	Title	Definition
C3	Partial Approval	Enter this code to indicate the bill has been reviewed by the PRO and some portion (days or services) has been denied. From/Through dates of the approved portion of the stay are shown as code "MO" in FL 36. Exclude grace days and any period at a noncovered level of care (code "77" in FL 36 or code "46" in FL 39-41).
C4	Admission Denied	Enter this code to indicate patient's need for inpatient services was reviewed and the PRO found that none of the stay was medically necessary.
C5	Postpayment Review Applicable	Enter this code to indicate that any medical review will be completed after the claim is paid. This bill may be a day outlier, cost outlier, part of the sample review, reviewed for other reasons, or may not be reviewed.
C6	Preadmission/Preprocedure	Enter this code to indicate that the PRO authorized this admission/procedure but has not reviewed the services provided.
C7	Extended Authorization	The PRO has authorized these services for an extended length of time but has not reviewed the services provided.
Claim Change Reasons		
D0	Changes to Service Dates	Self-explanatory
D1	Changes to Charges	Self-explanatory
D2	Changes to Revenue Codes/HCPCs	Self-explanatory.
D3	Second or Subsequent Interim PPS Bill	Self-explanatory
D4	Change in GROUPER Input	Self-explanatory.
D5	Cancel to Correct HICN or Provider ID	Cancel only to delete an incorrect HICN or Provider Identification Number.
D6	Cancel Only to Repay a Duplicate or OIG Overpayment	Cancel only to repay a duplicate payment or OIG overpayment (includes cancellation of an outpatient bill containing services required to be included on an inpatient bill.)

D7	Change to Make Medicare to the Secondary Payer	Self-explanatory.
D8	Change to Make Medicare the Primary Payer	Self-explanatory.
D9	Any Other Change	Self-explanatory.
E10	Change in Patient Status	Self-explanatory.
MO	All-Inclusive Rate for Outpatient Services (Payer Only Code)	Used by a Rural Primary Care Hospital electing to be paid on an all-inclusive rate for outpatient services.

Form Locator 32-36B

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

Due to the varied nature of occurrence and occurrence span codes, provisions have been made to allow the use of both type codes within each. The occurrence span code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as ten occurrence codes to be utilized.

With respect to occurrence codes, fields 32A-35A must be completed before the B fields. If all the occurrence code fields 32 A&B - 35 A&B are filled, then 36 occurrence span) A&B may be used to capture additional occurrence codes When Form Locator 36 is used in this way, the "Through" date is left blank.

Conversely with respect to occurrence span codes, when Form Locator 36A&B are filled to capacity, Form Locators 34 & 35 may also be utilized to contain the "From" and "Through" dates of an additional occurrence span code. In this case, the code in Form Locator code 34 will be the occurrence span code and the occurrence span "From" date will be in the date field. Form Locator 35 would contain the same occurrence span code as the code in Form Locator 34, and the occurrence span "Through" date will be in the date field.

Occurrence codes have values from 01 through 69 and A1 - L9. Occurrence span codes have values from 70 through 99 and MO - Z9.

Examples of occurrence code uses:

The Medicare beneficiary retired on January 1, 1992 and the spouse retired on February 1, 1993. Therefore, Form Locator 32 should reflect code 18 and the date 010192 and Form Locator 33 should reflect code 19 and the date 020193.

Form Locator 32-35 A,B

Title: OCCURRENCE CODES AND DATES

Definition: The code and associated date defining a significant event relating to this bill that may affect claim processing.

Requirements: Entry required, if applicable.

Field Attributes:	CODE	DATE
	2 positions	8 positions
	Alphanumeric	Numeric (all positions)
	Left justified	
	(all positions fully coded)	

Note: Enter all dates in month, day, and year format (MMDDYYYY). Example: 10101996

Code Structure:

01	Auto Accident: Code indicating the date of an auto accident.
02	No-Fault - Insurance Involved - Including Auto Accident/Other: Code indicating the date of an accident including auto or other where state has applicable no-fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability: Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related: Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other Accident: Code indicating the date of an accident not described by the above codes. Explain in the "Remarks" section, Form Locator 84.
07-08	Reserved for National Assignment.
11	Onset of Symptoms/Illness: (OUTPATIENT BILLS ONLY) Code indicating the date the patient first became aware of symptoms/illness necessitating the following outpatient services: physical therapy (PT), speech therapy (ST), occupational therapy (OT), and cardiac rehabilitation.
12	Date of Onset for a Chronically Dependent Individual: HHA claims only. Code indicates the date the patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the three-month period immediately prior to the eligibility under the respite care benefit.
17	Date outpatient occupational therapy plan established or last reviewed: (OUTPATIENT BILLS ONLY) Code indicating the date an occupational therapy plan of treatment was established or last reviewed.

18	Date of Retirement Patient/Beneficiary: the date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse: The date of retirement for the patient's spouse.
20	Guarantee of Payment Began: Code indicating the date on which the provider began claiming Medicare payment under the Guarantee of Payment provision.
21	UR Notice Received (SNF claims only): Code indicating the date of receipt by the provider of the Utilization Review (UR) Committee's finding that the admission or future stay was not medically necessary.
22	Date Active Care Ended: Code indicates the date covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital. Code not required when code 21 (above) is used.
23	Benefits Exhausted: Code indicating benefits have exhausted during the billing period. For Medicare Intermediary Use Only.
24	Date Insurance Denied: Code indicating the date the denial of coverage was received by the provider from any insurer.
25	Date Benefits Terminated by Primary Payer: Code indicates the date on which coverage (including Workers Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available: Code indicating the date on which a SNF bed became available to a hospital inpatient who required only SNF level care.
27	Date of Hospice Certification or Re-Certification: Code indicates the date of certification or re-certification of the hospice benefit period.
28	Date comprehensive outpatient rehabilitation plan established or last reviewed: (CORF BILLS ONLY) Code indicating the date a comprehensive outpatient rehabilitation plan of treatment was established or last plan established or last reviewed. This entry is required on every CORF bill.
29	Date outpatient physical therapy plan established or last reviewed: (OUTPATIENT BILLS ONLY) Code indicating the date a physical therapy plan of treatment was established or last reviewed.
30	Date outpatient speech pathology plan established or last reviewed: (OUTPATIENT BILLS ONLY) Code indicating the date a speech pathology plan of treatment was established or last reviewed.
31	Date beneficiary notified of intent to bill (accommodations): The date of notice provided to the patient by the hospital that he does not (or no longer does) require covered level of inpatient care.
32	Date beneficiary notified intent to bill (procedures or treatments): The date of notice provided to the beneficiary that of requested care (procedures or treatments) are not considered reasonable or necessary under Medicare guidelines.

33	First day of Medicare coordination period for ESRD beneficiaries covered by EGHP. Code indicates the first day of Medicare coordination period during which Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP). Required only for End Stage Renal Disease (ESRD) beneficiaries.
34	Date of election of extended care families: Code indicates the date the individual elected to receive extended care services (used for Christian Science Sanatorium only).
35	Date treatment started for Physical Therapy (OUTPATIENT BILL ONLY) Code indicates the date services were initiated by the billing provider for physical therapy.
36	Date of Inpatient Hospital Discharge for Covered Transplant Patients: Code indicates the date of discharge for inpatient hospital stay in which the patient received a covered transplant procedure when the hospital is billing for immunosuppressive drugs. NOTE: When the patient received a covered and non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital Charge for Non-Covered Transplant Patients: Code indicates the date of discharge for the inpatient hospital stay in which the patient received only a non-covered transplant procedure when the hospital is billing for immunosuppressive drugs.
42	Date of Discharge: Hospice claims only. Code indicates the date on which the beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill.
43	Scheduled Date of Cancelled Surgery: The date for which ambulatory surgery was scheduled, however, the scheduled surgery did not occur.
44	Date treatment started for Occupational Therapy: (OUTPATIENT BILLS ONLY) The date services were initiated by the billing provider for occupational therapy.
45	Date treatment started for Speech Therapy: (OUTPATIENT BILLS ONLY) The date services were initiated by the billing provider for speech therapy.
46	Date treatment started for Cardiac Rehab: (OUTPATIENT BILLS ONLY) The date services were initiated by the billing provider for cardiac rehabilitation.
47-49	Payer Codes: These codes are set aside for payer use only. PROVIDERS DO NOT REPORT THESE CODES.
A1	Birthdate - Insured A: The birthdate of the individual in whose name the insurance is carried. (Entry must correspond to any entry made in Form Locator 58, Line A.)
B1	Birthdate - Insured B: The birthdate of the individual in whose name the insurance is carried. (Entry must correspond to any entry made in Form Locator 58, Line B.)
C1	Birthdate - Insured C: The birthdate of the individual in whose name the insurance is carried. (Entry must correspond to any entry made in Form Locator 58, Line C.)

A2	Effective Date Insured A Policy: A code indicating the first date insurance is in force. (Entry must correspond to any entry made in Form Locator 58, Line A.)
B2	Effective Date Insured B Policy: A code indicating the first date insurance is in force. (Entry must correspond to any entry made in Form Locator 58, Line B.)
C2	Effective Date Insured C Policy: A code indicating the first date is in force. (Entry must correspond to any entry made in Form Locator 58, Line C.)
AO	Reserved for National Assignment.
BO	Reserved for National Assignment.
CO	Reserved for National Assignment.
A3	Benefits Exhausted: Code indicates that the last date for which benefits are available and after which no payment can be made by Payer A.
B3	Benefits Exhausted: Code indicates that the last date for which benefits are available and after which no payment can be made by Payer B.
C3	Benefits Exhausted: Code indicates that the last date for which benefits are available and after which no payment can be made by Payer C.
C4-C19	Reserved for National Assignment.
JO-L9	Reserved for National Assignment.
M1-Z9	Reserved for National Assignment.

Form Locator 32-36B

GUIDELINES FOR OCCURRENCE AND OCCURRENCE SPAN UTILIZATION

Due to the varied nature of occurrence and occurrence span codes, provisions have been made to allow the use of both type codes within each. The occurrence span code can contain an occurrence code where the "Through" date would not contain an entry. This allows as many as ten occurrence codes to be utilized.

With respect to occurrence codes, fields 32A-35A must be completed before the B fields. If all the occurrence code fields 32 A &B - 35 A&B are filled, then 36 (occurrence span) A&B may be used to capture additional occurrence codes. When Form Locator 36 is used in this way, the "Through" date is left blank.

Conversely, with respect to occurrence span codes, when Form Locator 36 A&B are filled to capacity, Form Locators 34 & 35 may also be utilized to contain the "From" and "Through" dates of an additional occurrence span code. In this case, the code in Form Locator code 34 will be the occurrence span code and the occurrence span "From" date will be in the date field. Form Locator 35 would contain the same occurrence span code as the code in Form Locator 34, and the occurrence span "Through" date will be in the date field.

Occurrence codes have values from 01 through 69 and A1 - L9. Occurrence span codes have values from 70 through 99 and MO - Z9.

Examples of occurrence code uses:

The Medicare beneficiary retired on January 1, 1992 and the spouse retired on February 1, 1993. Therefore, Form Locator 32 should reflect code 18 and the date 010192 and Form Locator 33 should reflect code 19 and the date 020193.

Form Locator 32-35 A,B

Title: OCCURRENCE CODES AND DATES

Definition: The code and associated date defining a significant event relating to this bill that may affect claim processing.

Requirements: Entry required, if applicable.

Field Attributes:	CODE	DATE
	2 position	8 positions
	Alphanumeric	Numeric (all positions)
	Left justified (all positions fully coded)	

Note: Enter all dates in month, day, and year format (MMDDYYYY). Example: 10101996

Code Structure:

01	Auto Accident: Code indicating the date of an auto accident.
02	No-Fault Insurance Involved - Including Auto Accident/Other: Code indicating the date of an accident including auto or other where state has applicable no-fault liability laws (i.e., legal basis for settlement without admission or proof of guilt).
03	Accident/Tort Liability: Code indicating the date of an accident resulting from a third party's action that may involve a civil court process in an attempt to require payment by the third party, other than no-fault liability.
04	Accident/Employment Related: Code indicating the date of an accident allegedly relating to the patient's employment.
05	Other Accident: Code indicating the date of an accident not described by the above codes. Explain in the "Remarks" section, Form Locator 84.
07-08	Reserved for National Assignment.
11	Onset of Symptoms/Illness: (OUTPATIENT BILLS ONLY) Code indicating the date the patient first became aware of symptoms/illness necessitating the following outpatient services; physical therapy (PT), speech therapy (ST), occupational therapy (OT), and cardiac rehabilitation.
12	Date of Onset for a Chronically Dependent Individual: HHA claims only. Code indicates the date the patient/beneficiary became a chronically dependent individual (CDI). This is the first month of the 3-month period immediately prior to the eligibility under the respite care benefit.

17	Date outpatient occupation therapy plan established or last reviewed: (OUTPATIENT BILLS ONLY) Code indicating the date an occupational therapy plan of treatment was established or last reviewed.
18	Date of Retirement Patient/Beneficiary: The date of retirement for the patient/beneficiary.
19	Date of Retirement Spouse: The date of retirement for the patient's spouse.
20	Guarantee of Payment Began: Code indicating the date on which the provider began claiming Medicare payment under the Guarantee of Payment provision.
21	UR Notice Received (SNF claims only): Code indicating the date of receipt by the provider of the Utilization Review (UR) Committee's finding that the admission or future stay was not medically necessary.
22	Date Active Care Ended: Code indicates the date covered level of care ended in a SNF or general hospital, or date on which active care ended in a psychiatric or tuberculosis hospital. Code not required when code 21 (above) is used.
23	Benefits Exhausted: Code indicating benefits have exhausted during the billing period. For Medicare Intermediary Use Only.
24	Date Insurance Denied: Code indicating the date of denial of coverage was received by the provider from any insurer.
25	Date Benefits Terminated by Primary Payer: Code indicates the date on which coverage (including Workers Compensation benefits or no-fault coverage) is no longer available to the patient.
26	Date SNF Bed Available: Code indicating the date on which a SNF bed became available to a hospital inpatient who required only SNF level care.
27	Date of Hospice Certification or Re-Certification: Code indicates the date of certification or re-certification of the hospice benefit period.
28	Date comprehensive outpatient rehabilitation plan established or last reviewed: (CORF BILLS ONLY) Code indicating the date a comprehensive outpatient rehabilitation plan of treatment was established or last plan established or last reviewed. This entry is required on every CORF bill.
29	Date output physical therapy plan established or last reviewed: (OUTPATIENT BILLS ONLY) Code indicating the date a physical therapy plan of treatment was established or last reviewed.
30	Date outpatient speech pathology plan established or last reviewed: (OUTPATIENT BILLS ONLY) Code indicating the date speech pathology plan of treatment was established or last reviewed.
31	Date beneficiary notified of intent to bill (accommodations): The date of notice provided to the patient by the hospital that he does not (or no longer does) require covered level of inpatient care.

32	Date beneficiary notified intent to bill (procedures or treatments): The date of notice provided to the beneficiary that of requested care (procedures or treatments) are not considered reasonable or necessary under Medicare guidelines.
33	First day of Medicare coordination period for ESRD beneficiaries covered by EGHP: Code indicates the first day of Medicare coordination period during which Medicare benefits are secondary to benefits payable under an employer group health plan (EGHP). Required only for End Stage Renal Disease (ESRD) beneficiaries.
34	Date of election of extended care facilities: Code indicates the date the individual elected to receive extended care services (used for Christian Science Sanatorium only).
35	Date treatment started for Physical Therapy: (OUTPATIENT BILLS ONLY) Code indicates the date services were initiated by the billing provider for physical therapy.
36	Date of Inpatient Hospital Discharge for Covered Transplant Patients: Code indicates the date of discharge for inpatient hospital stay in which the patient received a covered transplant procedure when the hospital is billing for immunosuppressive drugs. NOTE: When the patient received a covered and non-covered transplant, the covered transplant predominates.
37	Date of Inpatient Hospital Charge for Non-Covered Transplant Patients: Code indicates the date of discharge for the inpatient hospital stay in which the patient received only a non-covered transplant procedure when the hospital is billed for immunosuppressive drugs.
42	Date of Discharge: Hospice claims only. Code indicates the date on which the beneficiary terminated his/her election to receive hospice benefits from the facility rendering the bill.
43	Scheduled Date of Cancelled Surgery: The date for which ambulatory surgery was scheduled, however, the scheduled surgery did not occur.
44	Date treatment started for Occupational Therapy: (OUTPATIENT BILLS ONLY). The date services were initiated by the billing provider for occupational therapy.
45	Date treatment started for Speech Therapy: (OUTPATIENT BILL ONLY). The date services were initiated by the billing provider for speech therapy.
46	Date treatment started for Cardiac Rehab: (OUTPATIENT BILLS ONLY). The date services were initiated by the billing provider for cardiac rehabilitation.
47-49	Payer Codes: These codes are set aside for payer use only. PROVIDERS DO NOT REPORT THESE CODES.
A1	Birthdate - Insured A: The birthdate of the individual in whose name the insurance is carried. (Entry must correspond to any entry made in Form Locator 58, Line A.)

B1	Birthdate - Insured B: The birthdate of the individual in whose name the insurance is carried. (Entry must correspond to any entry made in Form Locator 58, Line B.)
C1	Birthdate - Insured C: The birthdate of the individual in whose name the insurance is carried. (Entry must correspond to any entry made in form Locator 58, Line C.)
A2	Effective Date Insurance Policy: A code indicating the first date insurance is in force. (Entry must correspond to any entry made in Form Locator 58, Line A.)
B2	Effective Date Insured B Policy: A code indicating the first date Insurance is in force. (Entry must correspond to any entry made in Form Locator 58, Line B.)
C2	Effective Date Insured C Policy: A code indicating the first date insurance is in force. (Entry must correspond to any entry made in Form Locator 58, Line C.)
AO	Reserved for National Assignment.
BO	Reserved for National Assignment.
CO	Reserved for National Assignment.
A3	Benefits Exhausted: Code indicates that the last date for which benefits are available and after which no payment can be made by Payer A.
B3	Benefits Exhausted: Code indicates that the last date for which benefits are available and after which no payment can be made by Payer B.
C3	Benefits Exhausted: Code indicates that the last date for which benefits are available and after which no payment can be made by Payer C.
C4-C19	Reserved for National Assignment.
JO-L9	Reserved for National Assignment.
M1-Z9	Reserved for National Assignment.

Form Locator 32-36B

Title: OCCURRENCE SPAN CODE AND DATES

Definition: A code and the related dates that identify an event that relates to the processing of the claim.

Requirement: Entry required, if applicable

Field Attributes:	CODE	DATE
	2 positions	8 positions
	Alpha-numeric	Numeric
	(All positions fully coded)	(All positions fully coded)

Note: Enter all dates in month, day and year format (MMDDYYYY).
Example: 10011996

Code Structure:

70	Qualifying Stay dates for SNF Use Only	The from/through date of at least a 3-day hospital stay that qualifies the patient for Medicare payment of SNF services billed. Code can be used only by SNF for billing. (HIM 12, §§ 212.1 and 560)
70	Nonutilization Dates for Payer Use Only on Hospital Bills	THIS CODE IS FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
71	Prior Stay Dates	The from/through dates given by the patient of any hospital stay that ended within 60 days of this hospital or SNF admission.
72	First/Last Visit	The from/through dates of outpatient services. For use on outpatient bills only where the entire billing record is not represented by the actual From/through service dates of Form Locator 6 (Statement Covers Period).
73	Benefit Eligibility Period	The inclusive dates during which CHAMPUS medical benefits are available to a sponsor's beneficiary as shown on the beneficiary's ID card.

74	Noncovered Level of Care/Leave of Absence	The from/through dates of a period at a noncovered level of care or leave of absence in an otherwise covered stay, excluding any period reported by occurrence span code 76, 77 or 79 below.
75	SNF Level of Care	The from/through dates of a period of SNF level of care during an inpatient hospital stay. Code should be used only when the PSRO/PRO has approved the patient remaining in the hospital because of the nonavailability of an SNF bed. Code is not applicable to swing-bed cases. For hospitals under prospective payment, this code is needed in day outlier cases only.
EFFECTIVE: JANUARY 1, 1997		
LOCATOR 36		
8/6/96		
76	Patient Liability	The from/through dates of a period of non-covered care for which the hospital is permitted to charge the Medicare beneficiary. Code should be used only where the PRO or intermediary has approved such charges in advance and patient has been notified in writing at least 3 days prior to the from date of this period.
77	Provider Liability Period	The from/through dates of a period of non-covered care for which the provider is liable. Utilization is charged.
78	SNF Prior Stay Dates	The from/through dates given by the patient of any SNF or nursing home stay that ended within 60 days of this hospital or SNF admission.
79	Payer Code	THIS CODE IS SET ASIDE FOR PAYER USE ONLY. PROVIDERS DO NOT REPORT THIS CODE.
80-99	Reserved for State Assignment.	
MO	PRO/UR Approved Stay Dates	The first and last days that were approved where not all of the stay was approved. (Use when condition code C3 is used in form locators 24-30.)

M1	Provider Liability--Utilization	No Code indicates the From/Through dates of a period of noncovered care that is denied due to lack of medical necessity or as custodial care for which the provider is liable. The beneficiary is not charged with utilization. The provider may not collect Part A or Part B deductible or coinsurance fro the beneficiary.
M2-W9		Reserved for national assignment.
XO-Z9		Reserved for state assignment.

Which occurrence code number should be used to report an Onset of Symptoms/Illness?

Is the occurrence code for reporting an Onset of Symptoms/Illness code required for all inpatient and outpatient bills concerning therapy?

- Yes
- No

Form Locator 37 A, B, C

Title: INTERNAL CONTROL NUMBER (ICN) DOCUMENT CONTROL NUMBER (DCN)

Definition: The document control number (DCN) assigned to the original bill process by the intermediary to facilitate subsequent processing of any adjustment or cancel claim.

Required: Enter the control number assigned to the original bill here. Utilize on adjustment requests (Bill Type, FL 4 = XX7). When requesting an adjustment to a previously processed claim, insert the ICN/DCN of the claim to be adjusted. Payer A's ICN/DCN should be shown on line "A" in FL 37. Similarly, the ICN/DCN for Payer B and C should be shown on lines B and C respectively, in FL 37.

Field Attributes: 23 positions, alphanumeric, left justified.

Form Locator 39-41 A,B,C,D

Definition: A code structure to relate amounts or values to identified data elements necessary to process the claim for Medicare reimbursement.

Requirements: Entry required, if applicable.

Field Attributes:	CODE	AMOUNT/VALUE
	2 positions	9 positions
	Alphanumeric	Numeric
	(All positions fully coded)	Right justified

If more than one value code is shown for a billing period, codes are shown in ascending numeric sequence. There are four lines of data, line "a" through line "d." Use FLs 39a through 41a before 39b through 41b (i.e., use the first line before the second). (Only codes used to bill Medicare are shown.)

Code	Title	Definition
04	Inpatient Professional Component Charges Which Are Combined Billed	Enter this code to indicate the amount shown in the sum of the inpatient professional component charges which are combined billed. Medicare uses this information in internal processes and also in the HCFA notice of utilization sent to the patient to explain that Part B coinsurance applies to the professional component. (Used only by some all-inclusive rate hospitals.)
05	Professional Component Included in Charges and Also Billed Separate to Carrier	(Applies to Part B bills only.) Enter this code to indicate the charges shown are included in billed charges FL 47, but a separate billing for them will also be made to the carrier. For outpatient claims, these charges are excluded in determining the deductible and coinsurance due from the patient to avoid duplication when the bill for physician's services is processed by the carrier. These charges are also deducted when computing interim payment. Use this code also when outpatient treatment is for mental illness, and professional component charges are included in FL 47.

06	Medicare Blood Deductible	Enter this code to indicate the amount shown is the product of the number of unreplaced deductible pints of blood supplied times the charge per pint. If the charge per pint varies, the amount shown is the sum of the charges for each unreplaced pint furnished. If all deductible pints have been replaced, this code is not to be used. When you give a discount for unreplaced deductible blood, show charges after the discount is applied.
08	Medicare Lifetime Reserve Amount in the First Calendar Year in Billing Period	Enter this code to indicate the amount shown is the product of the number of lifetime reserve days used in the first calendar year of the billing period times the applicable lifetime reserve coinsurance rate. These are days used in the year of admission.
09	Medicare Coinsurance Amount in the First Calendar Year in Billing Period	Enter this code to indicate the amount shown is the product of the number of coinsurance days used in the first calendar year of the billing period [multiplied] multiplied by the applicable coinsurance rate. These are days used in the year of admission. Do not use this code on Part B bills.
10	Medicare Lifetime Reserve Amount in the Second Calendar Year in Billing period.	Enter this code to indicate the amount shown is the product of the number of lifetime reserve days used in the second calendar year of the billing period multiplied by the applicable lifetime reserve rate. Use the code only on bills spanning 2 calendar years when lifetime reserve days were used in the year of discharge.
11	Medicare Coinsurance Amount in the Second Calendar Year in Billing Period	Enter this code to indicate the amount shown is the product of the number of coinsurance days used in the second calendar year of the billing period times the applicable coinsurance rate. Use this code only on bills spanning 2 calendar years when coinsurance days were used in the year of discharge. Do not use this code on Part B bills.

12	Working Aged Beneficiary/Spouse With an EGHP	Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an aged beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed proper claim.
13	ESRD Beneficiary in a Medicare Coordination Period with an EGHP	Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of an ESRD priority beneficiary that the provider is applying to covered Medicare charges on the bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
14	No-Fault, Including Auto/Other Insurance	Enter this code to indicate the amount shown is that portion of a higher priority no-fault insurance payment including auto/other insurance, payment made on behalf of a Medicare beneficiary that the provider is applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because the other insurer has denied coverage or there has been a substantial delay in its payment. Where the provider received no payment or a reduced no-fault payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.

15	WC	Enter this code to indicate the amount shown is that portion of a higher priority WC insurance payment, made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment. Where the provider received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
16	PHS, Other Federal Agency	Enter this code to indicate the amount shown is that portion of a higher priority PHS or other Federal agency's payment, made on behalf of a Medicare beneficiary, that you are applying to Medicare charges. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment.
17-20	Payer Codes	(For internal use by third party payers only.)
31	Patient Liability Amount	Enter this code to indicate the amount shown was approved to charge the beneficiary for noncovered accommodations, diagnostic procedures or treatments.
37	Pints of Blood Furnished	Enter the total number of pints of whole blood or units of packed red cells furnished, whether or not they were replaced. Blood is reported only in terms of complete pints rounded upwards, e.g., 1-1/4 pints is shown as 2 pints. This entry serves as a basis for counting pints towards the blood deductible.
38	Blood Deductible Pints	Enter the number of unreplaced deductible pints of blood supplied. If all deductible pints furnished have been replaced, no entry is made.

39	Pints of Blood Replaced	Enter the total number of pints of blood which were donated on the patient's behalf. Where one pint is donated, one pint is considered replaced. If arrangements have been made for replacement, pints are shown as replaced. Where the provider charges only for the blood processing and administration (i.e., it does not charge a "replacement deposit fee" for unreplaced pints), the blood is considered replaced for purposes of this item. In such cases, all blood charges are shown under the 39X revenue code series (blood administration) or under the 30X revenue code series (laboratory).
40	New Coverage Not Implemented by HMO	Enter this code to indicate the amount shown is for inpatient charges covered by the HMO. (Use this code when the bill includes inpatient charges for newly covered services which are not paid by the HMO. Also, report condition codes 04 and 78.)
41	Black Lung (BL)	Enter this code to indicate the amount shown is that portion of a higher priority BL payment made on behalf of a Medicare beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment because there has been a substantial delay in its payment. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.
42	VA	Enter this code to indicate the amount shown in that portion of a higher priority VA payment made on behalf of a Medicare beneficiary that you are applying to Medicare charges on this bill.
43	Disabled Beneficiary Under Age 65 With EGHP	Enter this code to indicate the amount shown is that portion of a higher priority EGHP payment made on behalf of a disabled beneficiary that you are applying to covered Medicare charges on this bill. Enter six zeros (0000.00) in the amount field, if you are claiming a conditional payment because the EGHP has denied coverage. Where you received no payment or a reduced payment because of failure to file a proper claim, enter the amount that would have been payable had you filed a proper claim.

44	Amount Provider Agreed to Accept from Primary Payer When this Amount is Less than Charges but Higher than Payment Received	Enter this code to indicate the amount shown is that portion that you were obligated or required to accept from a primary payer as payment in full when that amount is less than charges but higher than the amount actually received. A Medicare secondary payment is due.
46	Number of Grace Days	If a code "C3" or "C4" is in FL 24-30, indicating that the PRO has denied all or a portion of this billing period, show the number of days determined by the PRO to be covered while arrangements are made for the patient's post discharge. The field contains one numeric digit.
47	Any Liability Insurance	Enter this code to indicate the amount shown is that portion from a higher priority liability insurance paid on behalf of a Medicare beneficiary that the provider is applying to Medicare covered charges on this bill. Enter six zeros (0000.00) in the amount field if you are claiming a conditional payment.
48	Hemoglobin Reading	Enter this code to indicate the latest hemoglobin reading taken during the billing cycle. Report in three positions with a decimal. Use the position to the right of the delimiter for the third digit.
49	Hematocrit Reading	Enter this code to indicate the latest hematocrit reading taken during this billing cycle. This is usually reported in two positions (a percentage) to the left of the dollar/cent delimiter. If the reading is provided with a decimal, use the position to the right of the delimiter for the third digit.

50	Physical Therapy Visits	Enter this code to indicate the number of physical therapy visits from onset (at the billing provider) through this billing period.
51	Occupational Therapy Visits	Enter this code to indicate the number of occupational therapy visits from onset (at the billing provider) through this billing period.
52	Speech Therapy Visits	Enter this code to indicate the number of speech therapy visits from onset (at the billing provider) through this billing period.
53	Cardiac Rehabilitation Visits	Enter this code to indicate the number of cardiac rehabilitation visits from onset (at the billing provider through this billing period.
56	Skilled Nurse--Home Visit Hours (HHA only)	Enter the number of hours of skilled nursing provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole hours, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour.)
57	Home Health Aide--Visits	Enter the number of hours of home health aide visit Hours (HHA only) services provided during the billing period. Count only hours spent in the home. Exclude travel time. Report in whole dollars, right justified to the left of the dollars/cents delimiter. (Round to the nearest whole hour.)
NOTE: Codes 50-57 and 60 are not money amounts but represent the number of visits. Entries for the number of visits are right justified from the dollars/cents delimiter as follows: | | | | | | |1|3|		
58	Arterial Blood Gas	Enter this code to indicate arterial blood gas value at the beginning of each reporting period for oxygen therapy. This value or value 59 is required on the initial bill for oxygen therapy and on the fourth month's bill. Report right justified in the cents area. (See note following code 59 for an example.)
59	Oxygen Saturation (O2 Sat/Oximetry)	Enter this code to indicate oxygen saturation at the beginning of each reporting period for oxygen therapy. This value or value 58 is required on the initial bill for oxygen therapy and on the fourth month's bill. Report right justified in the cents area. (See note following this code for an example.)

NOTE:	Codes 58 and 59 are not money amounts. They represent arterial blood gas or oxygen saturation levels. Round to two decimals or to the nearest whole percent. For example, a reading of 56.5 is shown as: | | | | | | |5|7| A reading of 100 percent is shown as: | | | | | |1|0|0|	
60	HHA Branch MSA	Enter the MSA in which HHA branch is located. (Report MSA when branch location is different than the HHA's--Report the MSA number in dollar portion of the form locator, right justified to the left of the dollar/cents delimiter.)
61-66	Reserved for National Assignment.	
67	Peritoneal Dialysis	Enter the number of hours of peritoneal dialysis provided during the billing period. Count only the hours spent in the home. Exclude travel time. Report in whole hours, right justify to the left of the dollar/cent delimiter. (Round to the nearest whole hour.)
68	Number of Units of EPO Provided During the Billing Period	Enter this code to indicate the number of units of EPO administered and/or supplied relating to the billing period. Report in whole units to the left of the dollar/cent delimiter. For example, 31,060 units are administered for the billing period. Thus, 31,060 is entered as follows: | |3|1|0|6|0| | |
70-71	Payer Codes	(For use by third party payers only.)
A1	Deductible Payer A	Enter the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
A2	Coinsurance Payer A	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
A3	Estimated Responsibility	The amount estimated by the provider to be paid by the indicated payer.
A4	Covered Self-Administrable	The amount included in covered charges for self-drugs-emergency administrable drugs administered to the patient in an emergency situation.
B1	Deductible Payer B	Enter the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.

B2	Coinsurance Payer B	Enter the amount assumed by the provider to be applied toward the patient's coinsurance amount involving the indicated payer.
B3	Estimated Responsibility	The amount estimated by the provider to be paid by the indicated payer
C1	Deductible Payer C	Enter the amount assumed by the provider to be applied to the patient's deductible amount involving the indicated payer.
C2	Coinsurance Payer C	Enter the amount assumed by the provider to be applied toward the (?)
C3	Estimated Responsibility	The amount estimated by the provider to be paid by the indicated payer
D3	Estimated Responsibility	The amount estimated by the provider to be paid by the patient

Form Locators 39-41: What is the title of this field?

Is entry optional or required if applicable?

- Optional
- Required

Which value code number should be used to report "blood that has been replaced or is considered to be/expected to be replaced?"

Form Locator 42

Title: REVENUE CODE

Definition: A code which identifies the specific type of service being billed by line item (e.g., accommodation, ancillary service).

Requirements: Entry required. Enter the appropriate three-digit numeric revenue code to identify each line item charge reported in Form Locator 47.

Field Attributes: 4 positions, numeric, right justified

Note: List revenue codes in ascending numeric sequence and do not (?) real revenue codes on the same bill to the extent possible.

To limit the number of line item entries on each bill, sum like revenue codes and report each revenue code only once, except when distinct HCPCS code reporting requires repeating a revenue code (e.g., laboratory services - revenue code 300 - repeated with different HCPCS codes), or an accommodation revenue code requires repeating with a different rate.

Revenue code 001 (Total Charges) should always be the final revenue code entry.

Some revenue codes require CPT/HCPCS codes, units and/or rates Providers can access the intermediary's on-line revenue code table via the Direct Data Entry (DDE) system, or reference a hardcopy table via the intermediary's UB-92 Manual (Medicare Part A and UB-92), which is available for purchase.

Go to the following Web site for purchase information:

www.hcfa.gov

Revenue code 001 (total charges) should always be the final entry on the claim.

- True
- False

Form Locator 43

Title: Revenue Description

Definition: A narrative description of the related revenue categories included on this bill.

Requirements: Entry is optional.

Field Attributes: 24 positions, alphanumeric, left justified

Notes: The description should correspond with the revenue codes as defined by the National Uniform Billing Committee, and abbreviations may be used. Descriptions or abbreviations correspond to revenue codes. "Other" code category descriptions are locally defined and individually described on each bill.

The investigational device exemption (IDE) or procedure identifies a specific device used only for billing under the specified revenue code 624. The IDE will appear on the paper format of form HCFA 1450 as follows: FDA IDE #A123456 (17 spaces).

The narrative description for each revenue code is required on the claim.

- False
- True

Form Locator 44

Title: HCPCS/RATES

Definition: The accommodation rate for inpatient bills and the HCFA Common Procedure Coding System (HCPCS) applicable to ancillary services.

Requirements: Entry required, if applicable.

Field Attributes: 9 positions, numeric (for rates), right justified (for rates), alpha-numeric (for HCPCS), left justified (for HCPCS)

Inpatient Bills: When multiple rates exist for the same accommodation revenue code (e.g., semi-private room at $150 and $200), a separate revenue line item should be used to report each rate, and the same revenue code (e.g., 120) should be reported on each line.

Outpatient: HCPCS coding must be reported for specific outpatient services which include, but are not limited to:

- Outpatient clinical diagnostic laboratory services billed to Medicare, enter the HCPCS code describing the lab service;
- Outpatient hospital bills for Medicare defined "surgery" procedure;
- Outpatient hospital bills for outpatient partial hospitalization;
- Radiology and other diagnostic services;
- Orthotics and prosthetics;
- ESRD drugs, supplies and laboratory services; and
- Other provider services in accordance with HCFA billing guidelines.

Form Locator 44 is used to report applicable rates for inpatient claims and HCPCS codes for outpatient claims.

- True
- False

Form Locator 45

Title: SERVICE DATE

Definition: The date the indicated line item service was provided.

This field is also used to report the assessment reference date when billing SNF PPS services (Type of Bill 21X).

Required on Medicare claims submitted on Type of Bill 21X when Form Locator (FL) 42 contains revenue code 0022 (SNF PPS) unless FL44 contains HIPPS Rate Code AAA00.

The line item service date should be reported in month/day/year format (MMDDYYYY).

Field Attributes: 8 positions numeric right justified (all positions fully coded)

Outpatient claims containing CPT/HCPCS clinical diagnostic laboratory codes (range 8002-89399) and spanning two or more days of service must have line item service dates reported.

- True
- False

Form Locator 46

Title: UNITS OF SERVICE

Definition: A quantitative measure of services rendered by revenue category to include items such as number of accommodation days, miles, pints of blood, or renal dialysis treatments, etc.

Requirements: Entry required as appropriate. Enter the total number of covered accommodation days, ancillary units of time or visits, where appropriate. A unit may be a measurement of time based on HCPCS association (i.e., 15 minute intervals for 60 minutes = 4 units).

Field Attributes: 7 positions, numeric, right justified

Units of Service (Form Locator 46) should reflect the measurement of time, number of services or number of treatments, not individual modalities within a service.

- True
- False

Form Locator 47

Title: TOTAL CHARGES (BY REVENUE CODE CATEGORY)

Definition: The total charges pertaining to the related revenue code line item for the current billing period reported in Form Locator 6 (Statement Covers Period).

Requirements: Entry required.

Field Attributes: 10 positions, numeric, right justified

Note: The line item charges reported in Form Locator 47 must add up to a grand total of all covered and non-covered charges which is reported in this form locator using the revenue code 001 (Total Charges).

Entry of "Total Charges" (from Locator 47) is an optional entry field.

- True
- False

Form Locator 48

Title: NON-COVERED CHARGES

Definition: To reflect Medicare non-covered charges related to a specific revenue code or line item.

Requirements: Entry required, if applicable.

Field Attributes: 10 positions, numeric, right justified

Note: Any non-covered charges reported in Form Locator 48 must add up to a total which is reported in this form locator using the revenue code 001 (Total Charges).

Non-covered charges represent charges for services not payable/reimbursable by the Medicare program.

- True
- False

Form Locator 50 A,B,C

Title: PAYER IDENTIFICATION

Definition: Name and/or code identifying each payer organization form which the provider expects some payment or has received payment for the bill.

Requirements: Entry required.

If Medicare is the primary payer, enter "Medicare" on Line 50A. Entering Medicare indicates that the provider developed for other insurance and determined that Medicare is the primary payer. If there are payer(s) of higher priority than Medicare, then enter the name of the higher priority payer on Line A.

If Medicare is the secondary payer, identify the primary payer on Line A and enter "Medicare" on Line B.

To report supplemental insurance, enter "Medicare" on Line A and enter the secondary (supplemental) insurer on Line B.

If Medicare is the tertiary payer, identify the primary payer on Line A and the secondary payer on Line B and enter "Medicare" on Line C.

Field Attributes: 25 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

ELECTRONIC MEDIA CLAIMS (EMC) ONLY - Use the following list of codes when submitting electronic claims to Medicare part A, Blue Cross and Blue Shield of Florida, Inc. Other payers may require codes not reflected.

Code	Description
1	Medicaid
2	Blue Cross
3	Other
4	None
A	Working Aged - Employer Group Health Plan (EGHP)
B	End Stage Renal Disease (ESRD) beneficiary in the coordination period with an Employer Group Health Plan (EGHP)
C	Conditional Payment
D	Automobile, no-fault or any liability insurance
E	Worker's Compensation
F	Public Health Service (PHS) or other Federal Agency
G	Disabled - Large Group Health Plan (LGHP)
H	Black Lung (Federal Black Lung Program)
I	Veteran's Administration
Z	Medicare

"Payer Identification" (form locator 50) does not have to be reported in any particular order (e.g., primary, secondary, etc.).

- True
- False

FORM LOCATOR 51 A, B, C

Title: PROVIDER NUMBER

Definition: The number assigned to the provider by Medicare.

Requirements: Entry required.

Field Attributes: 13 positions, numeric, right justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

The Medicare provider number entry must correspond to the Medicare payer identification information entered in Form Locator 50, Lines A, B and C.

- In other words, when "Medicare" is reported in Form Locator 50, Line A, the Medicare provider number is reported in Form Locator 51, Line A.

- If "Medicare" is reported as secondary payer in Form Locator 50, Line B, the Medicare provider number is reported in Form Locator 51, Line B.

Medicare Provider Number

The Medicare Part A provider number consists of six digits:

- The first two digits represent the State designation (e.g., the state designation for Florida is "10"); and

- The last four digits indicate the type of institution or facility.

A provider number is a required entry on the UB92.

- True

- False

Form Locator 52 A,B,C

Title: RELEASE OF INFORMATION CERTIFICATION INDICATOR

Definition: The code indicating whether the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim.

Requirements: Entry is required.

Field Attributes: 1 position, alphanumeric, left justified

Note: Line A Primary Payer
Line B Secondary Payer
Line C Tertiary

Code Structure:

Y - Yes	The provider has signed written authority to release medical/billing information for purposes of claiming insurance benefits
R - Restricted	The provider has limited or restricted authority to release some medical/billing information for purposes of claiming insurance benefits.
N - No Release	The provider does not have permission to release any medical/billing information.

Form Locator 54 A,B,C, P

Title: PRIOR PAYMENTS - PAYER AND PATIENTS

Definition: The amount the provider has received toward payment of this bill prior to submitting the bill to Medicare.

Requirements: Entry required, if applicable. Enter any amount received from the patient under Form Locator 54 (Due From Patient).

Field Attributes: 10 positions, numeric, right justified

Note: Line A Primary Payer
Line B Secondary Payer
Line CTertiary

Form Locator 58 A, B, C

Title: INSURED'S NAME

Definition: The name of the individual in whose name the insurance is carried.

Requirements: Entry required.

Enter the following patient information: last name, first name, and middle initial, if any. Name must be the same as on the patient's Health Insurance Card or other Medicare notice. Medicare requires the insured's name for the primary payer line where Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 25 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

The entry for "insured's name" may differ from the name of the Medicare beneficiary and/or patient.

The insured's name entry must correspond to the payer identification information entered in Form Locator 50, Line A, B, and C respectively.

Form Locator 59 A, B, C

Title: PATIENT'S RELATIONSHIP TO INSURED

Definition: A code indicating the relationship of the patient to the identified insured.

Requirements: Entry required.

Medicare requires the primary payer information on the primary payer line when Medicare is secondary or provider has requested conditional payment.

Field Attributes: 2 positions, numeric, right justified

Note: Line 2 Primary payer
Line B Secondary payer
Line C Tertiary payer

Code Structure:

01	Patient is Insured	Self-explanatory.
02	Spouse	Self-explanatory.
03	Natural Child/Insured Financial Responsibility	Self-explanatory.
04	Natural Child/Insured does not have Financial Responsibility	Self-explanatory.
05	Step Child	Self-explanatory.
06	Foster Child	Self-explanatory.
07	Ward of the Court	Patient is ward of the insured as a result of a court order.
08	Employee	Patient is employed by the insured.
09	Unknown	Patient's relationship to the insured is unknown.
10	Handicapped Dependent	Dependent child whose coverage extends beyond normal termination age limits as a result of laws or agreements extending coverage.
11	Organ Donor	Code is used in cases where bill is submitted for care given to organ donor where such care is paid by the receiving patient's insurance coverage.
12	Cadaver Donor	Code is used where bill is submitted for procedures performed on cadaver donor where such procedures are paid by the receiving patient's insurance coverage.
13	Grandchild	Self-explanatory.
14	Niece/Nephew	Self-explanatory.
15	Injured Plaintiff	Patient is claiming insurance as a result of injury covered by insured.
16	Sponsored Dependent	Individual not normally covered by insurance coverage, but coverage has been specially arrange to include relationships, such as grandparent or former spouse, that would require further investigation by the payer.
17	Minor Dependent of a Minor Dependent	Code is used where patient is a minor and a dependent of another minor who in turn is a dependent (although not a child) of the insured.
18	Parent	Self-explanatory.
19	Grandparent	Self-explanatory.
20	Life Partner	Patient is covered under insurance policy of his/her life partner (or similar designation, e.g., domestic partner, significant other).
21-99	Reserved for National Assignment.	

Form Locator 60 A,B,C

Title: CERTIFICATE/SOCIAL SECURITY NUMBER/HEALTH INSURANCE CLAIM/IDENTIFICATION NUMBER

Definition: Insured's unique identification number assigned by the payer organization.

Requirements: Entry required.

Enter the patient's Medicare number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, Hospital Transfer Form, or as reported by the Social Security Office. Medicare requires the primary payer information on the primary payer line when Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 19 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Form Locators 58-60 are used to report insurance information relative to the insured individual (who may or may not be the Medicare patient) and the required fields.

- True
- False

Form Locators 61 A,B,C

Title: INSURED GROUP NAME

Definition: Name of the group or plan through which the insurance is provided to the insured.

Requirements: Entry required, if applicable.

Medicare requires the primary payer information on the primary payer line when Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 14 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Form Locators 62 A,B,C

Title: INSURANCE GROUP NUMBER

Definition: The identification number, control number, or code assigned by the carrier or administrator to identify the group under which the individual is covered.

Required: Entry required, if applicable.

Medicare requires the primary payer information on the primary payer line when Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 17 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Form Locators 63 A,B,C

Title: TREATMENT AUTHORIZATION CODE

Definition: The number or other indicator that designates that the treatment covered by this bill has been authorized by the payer.

Requirements: Entry required, if applicable.

If PRO review has been performed for outpatient pre-admission, or pre-procedure, Home IV therapy services, the authorization number is required for all approved admissions or services. (HMO pre-authorization codes may also be reported in this field.)

Field Attributes: 18 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Form Locators 64 A, B,C

Title: EMPLOYMENT STATUS CODE

Definition: The code used to define the employment status of the individual identified in Form Locator 58 (Line A, B, or C).

Requirements: Entry required, if applicable.

Medicare requires the primary payer information on the primary payer line when Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 1 position, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Code Structure:

Code	Code Title	Definition
1	Employed full-time	Individual states that he/she is employed full-time.
2	Employed part-time	Individual states that he/she is employed part-time.
3	Not employed	Individual states that he/she is not employed full-time or part-time.
4	Self-employed	Self-explanatory.
5	Retired	Self-explanatory.
6	On Active Military Duty	Self-explanatory.
7-8	Reserved for National Assignment.	
9	Unknown Individuals	Employment status is unknown.

Form Locators 65 A,B,C

Title: EMPLOYER NAME

Definition: The name of the employer who provides health care coverage for the insured individual identified in Form Locator 58 (Line A, B, or C)

Requirements: Entry required, if applicable.

Medicare requires the primary payer information on the primary payer line when Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 24 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Form Locators 66 A,B,C

Title: EMPLOYER LOCATION

Definition: The specific location of the employer of the insured individual identified in Form Locator 58 (Line A, B, or C).

Requirements: Entry required, if applicable.

Medicare requires the primary payer information on the primary payer line when Medicare is secondary or the provider has requested conditional payment.

Field Attributes: 35 positions, alphanumeric, left justified

Note: Line A Primary payer
Line B Secondary payer
Line C Tertiary payer

Employment-related form locators 64-66 are optional fields if Medicare is the secondary payer and an employer group health plan (EGHP) is primary.

- True
- False

Form Locator 67

Title: PRINCIPAL DIAGNOSIS CODE

Definition: The ICD-9-CM code describing the principal diagnosis (i.e., the condition established after study to be chiefly responsible for the admission or the outpatient care).

Requirements:

Inpatient: Entry required. Enter full ICD-9-CM code for the condition established after study to be chiefly responsible for the admission of the patient for care. Even though another diagnosis may be more severe than the principal diagnosis, enter the code determined to be "principal" to the admission. Entering any other diagnosis code could result in an incorrect DRG assignment and provider overpayment.

If an alcohol and/or drug-related ICD-9-CM code is used as the principal diagnosis, it must be accompanied by a specific additional diagnosis code in form Locators 68-75 and/or 74, or 75 and/or a specific procedure code in Form Locators 80 or 81 to indicate whether the type of treatment provided involved rehabilitation and/or detoxification therapy (e.g., V5789).

Outpatient: Entry required. Enter full ICD-9-CM code for diagnosis shown in the provider records to be chiefly responsible for the outpatient services performed during the visit. Report the diagnosis to their highest degree of certainty. For instance, if the patient is seen on an outpatient basis for an evaluation of a symptom (e.g., cough) for which a definitive diagnosis is not made, the symptom is reported (786.2). If during the course of the outpatient evaluation and treatment, a definitive diagnosis is made (e.g., acute bronchitis), the definitive diagnosis is reported (466.0).

Field Attributes: 8 positions, alphanumeric, left justified

Note:

- The code reported must be the full ICD-9-CM diagnosis code, including all digits applicable (e.g., fourth digit or fifth digit).
- Where the proper code has fewer than four or five digits, do not fill with zeros.
- Do not include decimals in the diagnosis code (i.e., 289.50), report as the full ICD-9-CM code without the decimal (i.e., 28950).

- A working diagnosis is acceptable in the absence of a confirmed diagnosis. Where only testing is done and the physician requesting the test does not furnish the diagnosis, use ICD-9-CM code for Persons Without Reported Diagnosis Encountered During Examination, which is V70-V82.

A principal diagnosis is always required on the UB-92 claim.

- True
- False

Form Locator 68-75

Title: OTHER DIAGNOSIS CODES

Definition: The ICD-9-CM diagnosis codes corresponding to additional conditions that co-exist at the time of admission or outpatient service, or develop subsequently, and which have an effect on the treatment received or the length of stay.

Requirements: Entry required, if applicable.

Inpatient: Enter the full ICD-9-CM codes for other diagnoses that coexist at the time of admission or develop subsequently.

Outpatient: Enter ICD-9-CM codes for other diagnoses that co-exist at the time of outpatient treatment.

Field Attributes: 6 positions, alphanumeric, left justified.

Note:

- Other diagnoses codes will permit the use of ICD-9-CM "V" and "E" codes where appropriate.
- Codes reported must be the full ICD-9-CM codes, including all digit codes applicable (e.g., fourth digit or fifth digit).
- Where the proper code has fewer than four or five digits, do not fill with zeros.
- Do not duplicate the principal diagnosis code reported in Form Locator 67 as an additional or "other" diagnosis.
- Report "other" diagnosis codes in the order of highest priority.
- Do not include decimals in the diagnosis code (i.e., 289.50), report as the full ICD-9-CM code without the decimal (i.e., 28950).

Form Locator 76

Title: ADMITTING DIAGNOSIS

Definition: The ICD-9-CM diagnosis code provided at the time of admission as stated by the physician.

Requirements: Entry required for inpatient bills.

Field Attributes: 6 positions, alphanumeric, left justified

Note: The ICD-9-CM diagnosis code describing the admitting diagnosis as a significant finding representing patient distress, an abnormal finding on examination, a possible diagnosis based on significant findings, a diagnosis established from a previous encounter or admission, an injury, a poisoning, or a reason or condition (not an illness or injury). Report only one admitting diagnosis. The condition shall be determined based on the ICD-9-CM coding directives in Volumes I and III of the ICD-9-CM coding manuals and the official coding guidelines.

- Do not include decimals in the diagnosis code (i.e., 289.50); report as the full ICD-9-CM code without the decimal (i.e., 28950).

- The admitting diagnosis code may be repeated as a "principal" or "other diagnosis code (Form Locators 67-75).

An admitting diagnosis code is always required on inpatient claims.

- True

- False

Form Locator 77

Title: EXTERNAL CAUSE OF INJURY CODE (E-CODE)

Definition: The ICD-9-CM code or external cause of an injury, poisoning, or adverse effect.

Requirements: Entry not required.

Field Attributes: 6 positions, alphanumeric, left justified

Note: Health care facilities are encouraged to complete Form Locator 77 whenever there is a diagnosis of an injury, poisoning, or adverse effect. The completion of this field is voluntary in Florida (E-coding is not required).

The priorities for recording an E-code in Form Locator 77 are:

1. Principal diagnosis of an injury or poisoning

2. Other diagnosis of an injury, poisoning, or adverse effect directly related to the principal diagnosis; or

3. Other diagnosis with an external cause.

Form Locator 80

Definition: The code that identifies the principal procedure performed during the period covered by this bill and the date on which the principal procedure described on the bill was performed.

Requirements: Entry required for inpatient claims if applicable (i.e., if surgery was performed during the inpatient stay). Enter the full ICD-9-CM principal procedure and date the procedure was performed.

Field Attributes:	CODE	DATE
	7 positions	8 positions
	Alphanumeric	Numeric
	Left justified	Right justified

(all positions fully coded)

Note: Enter date in month, day, and year format (MMDDYYYY).

Example: 10011993

- Do not include decimals in the procedure code (i.e., 86.81); report as the full ICD-9-CM code without the decimal (i.e., 868.1).

- Providers report outpatient surgeries and other procedures via the HCFA Common Procedure Coding Structure (HCPCS), which includes the CPT coding structure.

- Providers use ICD-9-CM codes to report procedures on inpatient bills.

- Providers should generally not report both ICD-9-CM procedure codes and HCPCS procedure codes on inpatient or outpatient claims.

Form Locator 81

Title: OTHER PROCEDURE CODES AND DATES

Definition: The codes identifying all significant procedures, other than the principal procedure, and the dates on which the procedures were performed. Report those that are most important for the episode of care and specifically any therapeutic procedures closely related to the principal diagnosis.

Requirements: Entry required for inpatient claims if applicable (i.e., if surgery or other procedures were performed during the inpatient stay). Enter the full ICD-9-CM procedure codes and dates the procedures were performed.

Field Attributes:	CODE	DATE
	7 positions	8 positions
	Alphanumeric	Numeric
	Left justified	Right justified
(all positions fully coded)		

Note Enter codes in descending order of importance.

Enter date in month, day and year format (MMDDYYYY). Example: 10011993

- Do not include decimals in the procedure code (i.e., 86.81), report as the full ICD-9-CM code without the decimal (i.e., 8681).
- Providers report outpatient surgeries and other procedures via the HCFA Common Procedure Coding Structure (HCPCS), which includes the CPT coding structure.
- Providers use ICD-9-CM codes to report procedures on inpatient bills.
- Providers should generally not report both ICD-9-CM procedure codes and HCPCS procedure codes on inpatient or outpatient claims.

Form locators 80 and 81 should only be used for inpatient claims.

- True
- False

Form Locator 82

Title: ATTENDING PHYSICIAN

Definition: The name and/or number of the licensed physician who would normally be expected to certify and recertify the medical necessity of the services rendered and/or who has primary responsibility for the patient's medical care and treatment.

Requirements: Entry required. Enter the unique physician identification number (UPIN) and the name of the physician that requested the inpatient admission or outpatient services.

Inpatient: Enter the UPIN and name of the physician that requested the admission. Enter the UPIN in the first six positions the last name, one space, first initial.

Outpatient: Enter the UPIN and name of physician that requested the surgery, therapy, diagnostic tests or other outpatient services. Enter the UPIN in the first six positions, the physician's last name, one space, first initial.

If the patient was self-referred (e.g., emergency room or clinic visit), enter SLF000 in the first six positions, and do not enter a physician's name.

Electronic Media Claim (EMC): The EMC specifications (i.e., specific record and field) will vary depending on the EMC format utilized for submission.

Field Attributes:	1 field; upper line (optional), 23 positions, alphanumeric, left justified lower line, 32 positions, alphanumeric, left justified

Note: All Medicare claims require UPINs, e.g., including cases where there is a different primary insurer involved. UPINs may be obtained from the physicians rendering/ordering services.

Form Locator 83 A,B

Title: OTHER PHYSICIAN ID

Definition: The name and/or number of the licensed physician(s) designated as "other."

Requirements: Entry required, if applicable.

Inpatient: Enter the UPIN and name of the physician(s) who performed the principal or other procedures, if procedures are reported in form Locators 80 and 81. If no procedures are reported, leave blank.

Outpatient: Enter the UPIN and name of the physician(s) who performed the principal procedures, if HCPCS/CPT surgical procedures are reported in Form Locator 44.

Field Attributes:	2 fields; left justified upper line (optional), 25 positions, alphanumeric, lower line, 32 positions alphanumeric, left justified

Form Locator 84

Title: REMARKS

Definition: Notations providing any additional information necessary to adjudicate the claim.

Requirements: Entry desirable, when appropriate.

Field Attributes: 48 positions, alphanumeric, left justified

Note:

Where Medicare is not the primary payer because there is another payer of higher priority than Medicare involved, enter the address of the payer responsible (if not previously entered in Form Locator 38).

Enter any "remarks" needed to provide information that is not reported elsewhere on the bill but which may be necessary to ensure proper Medicare payment (e.g., explanation for adjustment or cancel bill).

Recommended Format of Standard Entries:

General: Print the following fields in each category across the single line with a single space separating each field.

1. To report the address of an insured when it is not the same as that of the patient.

    a) Code "ADDR-X" where X corresponds to Line A, B, or C based upon the payer identification reported in Form Locator 50.

    b) Street Address (24 characters)

    c) City and State (18 characters)

    d) Zip Code (5 characters)

2. To report overflow information (e.g., condition code, value code, occurrence code and occurrence span code).

    a) Code "FL" to indicate Form Locator number

    b) Provide appropriate code number

    c) Provide appropriate date(s) or value(s)

d) Separate multiple entries with a semicolon

e) Format example:

Occurrence span code: FL36:71, 10141993/11261993
Value code: FL39:09, 76.00, 11,89.00

Post-Course Knowledge Assessment

Welcome to the Post-Course Knowledge Assessment. You will be given 15 questions based on the content of this course. Answer the questions in any order that you like.

In order to successfully complete this module, you will need to score a 90% or higher. If you pass, you will be brought to a screen with your certificate. If you do not pass, we recommend that you study the information that caused you to fail and retake the final test when you are ready.

When you are ready to begin the test, click the Right Arrow button.
Good luck!

Form Locator 84, "Remarks", should only be used to report information necessary for proper processing of a claim.

- True
- False

Condition Code 11 must be reported on all bills (inpatient and outpatient) if therapy services were performed.

- True
- False

The patient's birthday must be reported using a four-digit year (MMDDYYYY).

- True
- False

Select the appropriate association between the six items.

1. First Digit	2. Second Digit	3. Third Digit
A. Frequency	B. Facility	C. Bill Classification

1.B 2.A 3.C
1.B 2.C 3.A
1.C 2.B 3.A
1.C 2.A 3.B

1. What is the type of bill code for an inpatient (Part A) hospital adjustment bill?

2. What is the type of bill code for an inpatient (Part B only) ancillary cancel/void bill?

(1) 177 (2) 182
(1) 17 (2) 28
(1) 128 (2) 117
(1) 117 (2) 128

Form locator 20, Source of Admission, is a required entry for Inpatient and Outpatient bills?

- True
- False

Occurrence code number 12 should be used to report an Onset of Symptoms/Illness?

- True
- False

Is the title of Form Locators 39-41 "VALUE CODES"?

- Yes
- No

Revenue code 001 (total charges) should always be the final entry on the claim.

- True
- False

Form locator 44 is used to report applicable rates for inpatient claims and HCPCS codes for outpatient claims.

- True
- False

Outpatient claims containing CPT/HCPCS clinical diagnostic laboratory codes and spanning two or more days of service must have line item service dates reported.

- True
- False

"Payer Identification" (form locator 50) does not have to be reported in any particular order (e.g., primary, secondary, etc.).

- True
- False

Employment-related form locators 64-66 are optional fields if Medicare is the secondary payer and an employer group health plan (EGHP) is primary.

- True
- False

A principal diagnosis code is always required on the UB-92 claim.

- True
- False

An admitting diagnosis code is always required on inpatient claims.

- True
- False

You scored ____ correct on the Post-Course Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click a numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

Your course "Progress Report" containing both the Preliminary Knowledge Assessment and Post-Course Knowledge Assessment scores can be obtained by clicking the Print Button below. HCFA 1450 course certification is given to individuals scoring 90% or better on the Post-Course Knowledge Assessment.

Note: You may increase your final score by retaking the Post-Course Knowledge Assessment at any time.

[End of HCFA Form 1450 Section]

Post-Course Knowledge Assessment

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Good luck!

Form Locator 84, "Remarks", should only be used to report information necessary for proper processing of a claim.

- True
- False

Condition Code 11 must be reported on all bills (inpatient and outpatient) if therapy services were performed.

- True
- False

The patient's birthday must be reported using a four-digit year (MMDDYYYY).

- True
- False

Select the appropriate association between the six items.

1. First Digit	2. Second Digit	3. Third Digit
A. Frequency	B. Facility	C. Bill Classification

1. B 2. A 3. C
1. B 2. C 3. A
1. C 2. B 3. A
1. C 2. A 3. B

(1) What is the type of bill code for an inpatient (Part A) hospital adjustment bill?

(2) What is the type of bill code for an inpatient (Part B only) ancillary cancel/void bill?

(1) 177 (2) 182
(1) 17 (2) 28
(1) 128 (2) 117
(1) 117 (2) 128

Form locator 20, Source of Admission,, is a required entry for Inpatient and Outpatient bills?

- True
- False

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- True
- False

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- Yes
- No

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- True
- False

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- True
- False

Outpatient claims containing CPT/HCPCS clinical diagnostic laboratory codes and spanning two or more days of service must have line item service dates reported.

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- False

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- True
- False

A principal diagnosis code is always required on the UB-92 claim.

- True
- False

An admitting diagnosis code is always required on inpatient claims.

- True
- False

Please access the Internet with your browser now.

Once connected to the Internet, click the button below.

If any messages appear, click "OK" to continue.

You scored ___ correct on the Post-Course Knowledge Assessment.

Refer to the button bar below to see which questions you answered correctly or incorrectly. Click a numbered button to view the correct response for each question. A green button indicates a correct answer. A red button indicates an incorrect answer.

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15

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